Chapter 23

SUPPORTING HUMAN RIGHTS AND ADDRESSING OPPRESSION IN PSYCHOTHERAPY

Human rights are those basic inalienable rights belonging to all people regardless of race, ethnicity, gender, sexual orientation, religion, age, ability, or any other factors. They are inherent in all of us simply because we are human. The United Nations affirmed these rights in 1948, publishing the *Universal Declaration of Human Rights* (UDHR). This historic document, drafted by representatives from different countries, defines basic human rights as the freedom, justice, inherent dignity, and equal and inalienable entitlements of all members of the human family (United Nations, 1948).

Human rights live at the core of the work we do as therapists. The values of justice, dignity, and respect are etched into our ethics codes as compasses that guide us toward the profession's highest ethical ideals and practices—that is, to benefit and not to harm those we serve. Principle-A, beneficence and nonmaleficence of the 2017 APA Ethics Code states that

> Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research (p. 3).

Principle-D of the APA Ethics Code underscores the importance of justice and equity by encouraging

> Psychologists [to] recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices (2017a, p. 4).

Principle-E of the APA Ethics code affirms respect for people's rights and dignity, stating

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices (2017a, p. 4).

Similarly, the 2017 CPA, Principle-I, emphasizes *Respect for the Dignity of Persons and Peoples* by stating that

> This principle, with its emphasis on inherent worth, non-discrimination, moral rights, distributive, social and natural justice, generally should be given the highest weight, except in circumstances in which there is a clear and imminent danger of bodily harm to someone (p. 4).

In countries outside of the Americas, psychologists have also come to underscore the importance of respecting and protecting human rights in our profession. For instance, in 2008 the International Union of Psychological Science (IUPS) adopted the *Universal Declaration of Ethical Principles for Psychologists* which call on psychologists across the globe to make a commitment to "placing the welfare of society and its members above the self-interest of the discipline and its members" (IUPS, 2008, para. 1). The declaration "reaffirms the commitment of the psychology community to help build a better world where peace, freedom, responsibility, justice, humanity, and morality prevail" (IUPS, 2008, para. 4). In Table 23.1, we list and describe the four universal ethical principles for psychologists and provide actionable exemplars.

Failing to protect human rights and ethics has dire consequences. Pope (2019, p. 190) provides six key principles to help safeguard human rights and professional ethics including:

Table 23.1. Universal Declaration of Ethical Principles for Psychologists and Actionable Exemplars.

Ethical Principles	Description	Actionable Exemplars
I. Respect for the Dignity of Persons and Peoples	– All human beings are inherently worthy of respect, dignity, and moral consideration. – Differences in race, ethnicity, culture, gender, national origin, sexual orientation, ability status, religion/faith/spirituality, age, and language are core components of peoples' identities and give meaning to their lives.	– Provide informed consent in the client's preferred language—use culturally syntonic language (consider connotations) that is free of academic and legal verbiage. – Learn about the history, traditions, beliefs, and values of the social groups your client belongs to and identifies with. – Align treatment goals to clients' cultural values and include them in the treatment planning process. – Affirm and validate clients' reactions to oppression.
II. Competent Caring for the Well-Being of Persons and Peoples	– Providing psychological services that improve people's lives and do no harm. – Developing awareness on how cultural values and personal experiences influence people's behaviors and mental processes.	– Use knowledge and skills that are culturally responsive (e.g., culturally adapted treatments), racially conscious (e.g., healing race-based stress and trauma), gender inclusive, queer affirming therapies, and respectful of clients' religion/faith/spirituality. – Address the effects of racism, anti-Semitism, and other forms of oppression on presenting problems and integrate them into an actionable treatment plan. – Help clients to not self-blame and instead help them externalize their oppression—in other words, put the onus on the institutions and systems that create and maintain oppression.
III. Integrity	– The public's confidence in the profession is built upon honest, truthful, and open communication. – Acknowledging, monitoring, and addressing biases and conflicts of interest that caused or may inflict harm to people. – Being mindful of protecting safety, confidentiality, and respect for cultural differences when disclosing information.	– Demonstrate a commitment to valuing transparency. Provide accurate information about services, how therapy works, limits of confidentiality, and who has access to health records. – Follow through with promises made to clients even if it takes extra time and effort. – Show an unwavering devotion to client's wellness by wearing multiple hats including counselor, teacher, guide, advocate, witness, consultant, therapist, and the like.

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Table 23.1. *(continued)*

IV. Professional and Scientific Responsibilities to Society	– Creating knowledge that supports understanding and respecting people who hold membership in multiple social groups and who are impacted by context and history. – Professional behavior and psychological practice that promote the well-being of society and all its members.	– Support and defend human rights. – Avoid being a passive bystander. Be ready to speak up against human rights violations. – Ecological validity matters. Create knowledge and develop interventions that are not only representative of different groups but also grounded in the cultural and racialized experiences of people (see Chapter 20).

1. The map is not the territory—prohibitions, policies, and public statements can mislead us if they are not matched by the behavior of individuals and the organization.
2. The power, authority, and demands of the state can never relieve us of our individual ethical responsibilities or our duty to support and defend human rights.
3. When human rights and fundamental ethics are at risk, we must always be prepared to speak up despite the costs, search actively for opposing views and disconfirming information, and avoid the role of passive bystander when whistle-blowers, critics, bearers of bad news, or others are threatened, bullied, smeared, or attacked.
4. We are more likely to think, speak, and write clearly when we avoid euphemisms, ambiguous terms, and equating "is it ethical?" with "is it effective?"
5. If we—as organizations or individuals—allow self-interest to eclipse our ethical responsibilities to other individuals, specific groups, or the general public, we weaken our ability to defend—or even to recognize and respect—human rights and ethics.
6. Searching our own attitudes and behaviors for arrogance can save us from countless blunders (as well as making life a lot easier for our friends and colleagues). If we look back at what we have written, said, and done since this crisis began and see nothing wrong—no flaws, mistakes, or "I wish I could take that back"—it is likely we have yet to completely master this principle.

Strengthening our ethical practice requires an unwavering commitment to anchoring our practice and decision-making process to human rights. To achieve this goal, we need to consider the different ways that individuals and groups are othered and oppressed. As you read through the next sections, we

invite you to consider the degree to which racism, sexism, heterosexism, ableism, anti-Semitism, and other forms of oppression have been neglected as an ethical issue in psychotherapy and how best we can navigate through the challenges and opportunities that arise when we attend to issues of systemic marginalization, discrimination, and oppression in psychotherapy.

ADDRESSING OPPRESSION IN PSYCHOTHERAPY

We all develop and live in a social context that ascribes different statuses to us based on physical characteristics (e.g., skin color, visible disability) and group memberships (e.g., ethnicity, gender, religion/faith, sexual orientation, immigration status). Some people belong to groups that are privileged—that is they are ascribed a high status and receive unearned advantages and resources. Individuals who belong to groups that are ascribed a lower status in society are othered, singled out, and rejected (Chavez-Dueñas et al., 2019). Othering serves as the foundation of oppression, which refers to the cultural, economic, and political subjugation and degradation of people due to their membership in a social group considered inferior by those with power in a given society (see Charlton, 1998; Collins, 2009; Corfee et al., 2020; Johnson et al., 2004; Lumsden & Harmer, 2019). Oppression is experienced across time and context, and when it shows up in therapy it confronts us with complex challenges and questions. Consider the following:

> You're a therapist working with a client you have seen for two sessions. Prior to your third session you reviewed the client's health records from their previous therapists. You read that the client has used hate speech directed at one or more groups. During the next session, you witness the client using the hate speech described in the records.

What does the scenario evoke in you? How do you envision yourself responding in the moment? How would you work with this client, if at all? What factors do you need to consider to guide your response? Does it make a difference to you what group is targeted (e.g., anti-Semitic vs. anti-Islamic vs. anti-Black vs. anti-immigrant hate speech)? What if the client tells you a joke they just heard that they think is hilarious—It involves the bombing of a synagogue, or a police officer kneeling on a Black man's neck until he's dead, or the state separating kids from their families and imprisoning them in cages. How may knowledge of history help you make sense of what is happening? How might your personal experience growing-up shape your interpretation of what is happening with this client? What if the tables were turned and you were the one who unintentionally behaved in an oppressive way in therapy? Or if the client made a statement that is hateful or offensive toward you?

Historically, issues of systemic marginalization, discrimination, and oppression were rarely framed or addressed as ethical issues in healthcare. However, more recently there have been a growing number of scholars who address oppressions in psychological theory, research, and practice (see French et al., 2020; Leong et al., 2017; Mosley et al., 2020; Turner & Neville, 2020). Theories proposed by Johnstone and Kanitsaki (2010) help us to understand the dominant practice of not addressing oppression, prejudice, and bias in healthcare—they state

> Given the significant and preventable moral harms caused by racism [and other forms of oppression] in healthcare, the question arises as to why, relative to other perplexing ethical issues in healthcare, racism [and other forms of oppression] has been poorly addressed and even ignored as an ethical issue in health service and health professional discourse? There are a number of reasons for this, including: the failure by philosophers and bioethicists to examine racism as an ethical issue and to show why it is morally wrong and hence ought to be rejected; the "illusion of non-racism in healthcare," that is, a genuine belief among health service providers that racism is not an issue any more; a subconscious association between raising awareness of the issue of racism in health care and whistleblowing; and related to all these considerations, an overwhelming sense that the issue is just "too hard" to deal with (p. 492).

These questions and explanations lead us to more challenging questions: What do I do now? How do we proceed when addressing discrimination and oppression in psychotherapy while staying anchored in the values of justice, dignity, and respect for people who are similar and different from us?

THE SOCIALIZATION AND OPPRESSION IN PSYCHOTHERAPY FRAMEWORK

Building on theories of intersectionality, socialization, and history, Figure 23.1 presents the *Socialization and Oppression in Psychotherapy (SOP)* framework. The SOP framework aims to help us recognize, acknowledge, understand, and consider the possible ethical pitfalls that arise when oppression is a part of the therapeutic context. The framework consists of four parts that include: (I) *historical context*; (II) *socialization*; (III) *overlapping forms of oppression*; and (IV) *therapeutic context*.

Part I: Historical Context and Socialization

Fostering a society where human rights are valued and respected requires us to learn, acknowledge, and understand the long history of colonization,

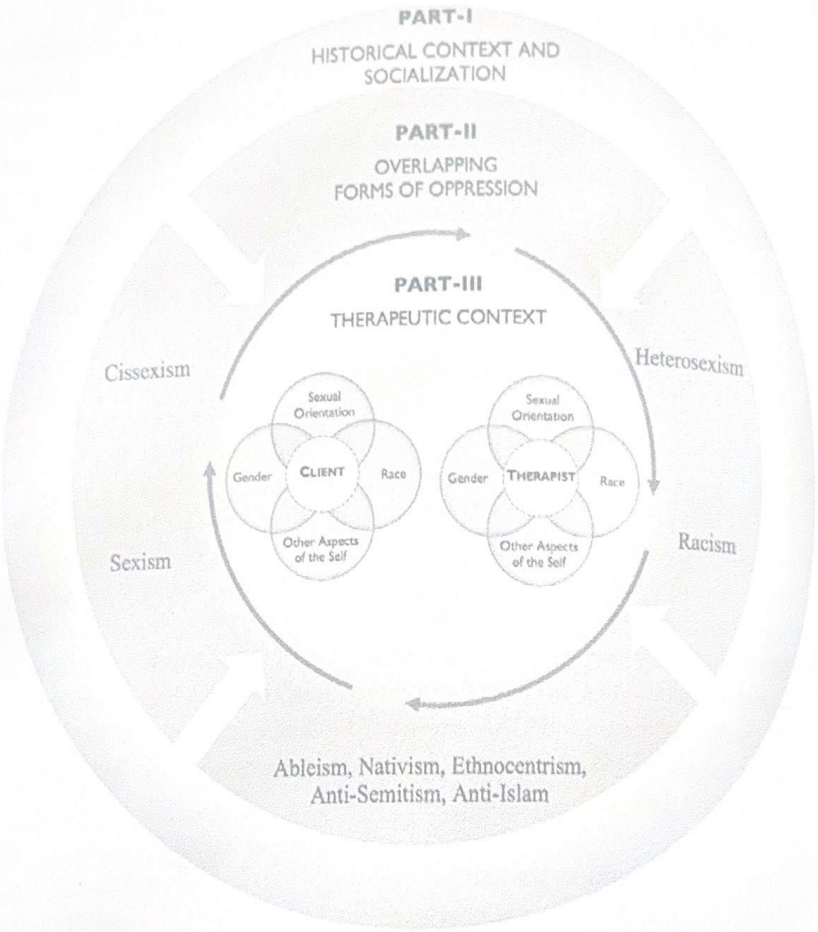

Figure 23.1 Socialization and Oppression in Psychotherapy (SOP) Framework.
Source: Pope, Vasquez, Chavez-Dueñas, & Adames (2021).

enslavement, segregation, dehumanization, and oppression that are part of the US and Canada and its impact on current inequities. In addition, it is important to recognize how this cultural context and history shapes our own development. In essence, and without our consent, we become a part of systems that are shaped by history which impact our experiences and access to opportunities. These systems are set in place to benefit some groups (e.g., White people, cisgender men, heterosexuals, able-bodied individuals) while systemically harming others (Black, Indigenous, People of Color, women, individuals with disabilities, sexual minorities, transgender individuals, gender non-conforming people). Throughout our childhoods we are inundated with messages about people with structural power and considered superior and those that are oppressed and treated as inferior. We pick up these messages first within our own families, who serve as the first, primary mechanism of

socialization in childhood. As we grow older the educational system, the media, and society also shape and inform our perceptions of ourselves and others. Learning about and from our collective history and socialization allows us a deeper, more accurate understanding of ourselves and our clients in context. History can also help us to "contextualize and understand our present day-to-day strengths, struggles, and realities" (Chavez-Dueñas & Adames, 2020, p. 1). Helping our clients consider the role of their collective history in their lives and experience can also be therapeutic (see Adames & Chavez-Dueñas, 2017; Chavez-Dueñas & Adames, 2020).

Recognizing and incorporating the role of history in our work as therapists can be key to effective work. It allows us to step away from an a-historic view that denies, discounts, or distorts historical and contextual forces that affect therapist, client, and their shared work. Chavez-Dueñas and Adames (2020) state:

> Suppressing or ignoring the role of history is unfortunately a common practice in professional programs that train people in the provision of mental health services. As a result, the practice of psychotherapy is often void of a process where the client and the therapist (a) stop to interrogate history, (b) planfully consider the role of systemic oppression on the presenting problem, and (c) incorporate the ways in which groups have survived and resisted their subjugation. Burying history, with all the richness and lessons it offers, leads to an inaccurate and negligible understanding of what may be bringing clients to therapy and how they can heal and thrive in the face of both intrapsychic distress and systemic oppression (p. 2).

Valid assessment and choice of intervention for a specific client depend on recognizing relevant context. Rosnow and Georgoudi (1986) wrote:

> The idea is that psychological knowledge is made concrete and is framed by relevant factors, relations, and conditions (the setting or context) within which, or among which, human acts unfold. Contextualism underscores the idea that human activity does not develop in a social vacuum, but rather it is rigorously situated within a sociohistorical and cultural context of meanings and relationships. Like a message that makes sense only in terms of the total context in which it occurs, human actions are embedded in a context of time, space, culture, and the local tacit rules of conduct (p. 4).

Shweder (1990) boiled it down to: "The ideas of a context-free environment, a meaning-free stimulus event, and a fixed meaning are probably best kept where they belong, along with placeless space, eventless time, and squared circles on that famous and fabulous list of impossible notions" (p. 8).

Part II: Overlapping Forms of Oppression

Assessing and addressing the role of oppression (e.g., racism, ethnocentrism, nativism, sexism, cissexism, heterosexism, ableism, anti-Semitism, anti-Islam) in our clients' lives not only aligns with our ethical principles (e.g., respect for people's rights and dignity) but also can strengthen the quality of care we deliver. Integrating the theory of intersectionality in therapy can help us to achieve this goal. Intersectionality theory, first introduced by Black feminists and Women of Color social justice activists and scholars (Collins, 2009; Combahee River Collective, 1977/1995; Crenshaw, 1989, 1991), focuses on the ways in which systems of oppression interlock in unique ways to impact individuals who hold membership in multiple socially constructed groups (Collins, 2009; Crenshaw, 1989, 1991).

Recognizing intersectional issues in the therapeutic context prompts us to question whether oppression is causing, maintaining, masking, or exacerbating our clients' presenting problems (Adames et al., 2018). When we fail to consider the role of oppression in our clients' lives, we may inadvertently blame them for their own oppression or rely on interventions that don't fit the individual.

Part III: The Therapeutic Context

The process of psychotherapy is complex. It includes the unique experiences of many worlds coming together in one space—two individuals (therapist and client), three individuals (therapist and couples), or more (therapist and family; therapist and group). Each person brings with them their individual and collective histories as well as the ways in which they are impacted due to their membership in multiple social groups based on race, ethnicity, gender, sexual orientation, religion, ability status and the like (depicted by the overlapping set of circles labeled "client" and "therapist" in Figure 23.1).

Intersectionality provides us with the language and framework to hold all of these complex, and at times conflicting, pieces together. Intersectionality can also help us deliver services that allow clients to avoid blaming themselves for their own oppression. Adames et al. (2018) state:

> An intersectional stance also helps appreciate that a significant part of the distress that ethnic minority individuals [other people who are oppressed] experience is caused by systems of oppression that operate in society. For instance, an intersectional stance can assist culturally responsive psychotherapists in helping clients explore the sources of their difficulties and challenge assumptions about the same. This kind of exploration can be particularly helpful and perhaps even essential with members of oppressed communities who are often socialized to internalize and blame themselves for the challenges they face (Adames & Chavez-Dueñas, 2017;

> Parham et al., 1999). Thus, an intersectional stance can serve as a way to give clients permission not to self-blame for experiencing symptoms that result from living in abnormal and oppressive environments. Through this therapeutic experience, clients can begin to learn about the role of systemic oppression and its effect on their sense of self-concept and self-worth (Adames & Chavez-Dueñas, 2017). As a result, an intersectional framework can assist in depathologizing many of the struggles oppressed communities experience, and open dialogue in therapy that can assist clients in generating alternative accounts of their reality and lived experiences. Moreover, when an intersectional stance is applied, clients may begin to feel more deeply seen and understood, trust the therapist, and believe that the therapist can help them (see Wampold, 2011, 2015). These nonspecific therapeutic factors can also serve to enhance the quality of the client–therapist relationship (p. 74).

Applying an intersectional framework in therapy can help us to recognize and understand clients' problems and distress in context (see Adames et al., 2020; Chavez-Dueñas et al., 2019). We become more open, alert to, and skilled at recognizing the ways systemic and institutional oppression can influence development, stunt flourishing, foster maladaptive behaviors, cause suffering and distress, and, if unrecognized by the clinician, send both assessment and interventions off-course.

Preparing to address oppression in therapy is not only complex but also emotionally loaded. Lee (2005) describes the double bind that therapists are placed in when addressing or remaining silent about racism and other forms of oppression in therapy. He states

> Why is there so much investment in preserving the silence around racism in clinical practice? While some of the explanations may be obvious, others may not be as readily apparent. I have heard White clinicians frequently express fears that they may say the wrong thing and come off sounding racist themselves. They describe the predicament of naming race in treatment and inadvertently offending a client of color (e.g., the client who says, "Why are you bringing up racism? Just because I'm Latino?") versus not naming race—even when it is begging for attention—and then being blamed for being insensitive and unaware. As one of my colleagues expressed in frustration: It's just not worth taking the risk. I realize that I don't have much experience talking about racism to others outside of the therapy context and even less so within the practice context. I don't like feeling out of control or vulnerable. So, it is easier for me just to not bring up the issue. I'd rather be accused of being unaware than be called a racist (p. 98).

An intersectional framework can also help us to pause, recognize, and consider that as therapists we too may hold membership in multiple minoritized groups. In other worlds, we can also be targets of oppression outside of and

within the therapeutic context. For instance, consider a gender non-conforming therapist working with a client who makes assumptions about the therapist's sexuality and uses homonegative and transnegative language. Or a Black cisgender women therapist working with a White cisgender gay male who uses derogatory racist language in therapy.

It is also possible that we may belong to groups with a history (perhaps stretching into the present) of oppressing others, and perhaps we ourselves have intentionally or carelessly engaged in anti-Semitism, anti-Islam, anti-Black, or other forms of oppression, or have remained passive bystanders and silent enablers as others in our group engaged in oppression.

Navigating Oppressive Encounters in Therapy

Witnessing a client making a racist, sexist, heterosexist, transnegative, ableist, anti-Semitic, anti-Islamic, nativist, or any other dehumanizing comments in the therapeutic context can elicit many emotions. If the comment targets a group you belong to, you may feel helpless and oppressed similar to other times when you encounter similar hateful comments and psychological injuries (e.g., race-based stress, minority-stress) outside of the therapeutic process. The reactions evoked by the encounter may make it difficult to decide how best to proceed. During these challenging therapeutic encounters, it is important to stay anchored to an implicit goal of psychotherapy—that is to create a relationship in which difficult things can be recognized and named when they happen. However, to do this work we need to develop both our own capacity as well as the client's capacity to address the difficult realities of bias, prejudice, and oppression between us and within us. Below we provide five actions that may be helpful in improving our skill at addressing and naming oppression in therapy and putting that skill to use in service of the client and the therapeutic process.

1. Pause and Pay Attention to Your Emotional Reactions

- Be mindful of your emotional reactions, automatic thoughts, and the social expectations that may blur how you respond in the moment.
- Recognize that deciding what to do is both an emotional task, and a professional ethical decision—thus, avoid making a hasty decision.

2. Contextualize the Exchange

- Assess the client's current mental status (e.g., disturbance in thinking or perception, delirium, neurocognitive issues).
- Consider the emotional state of the client: if they are extremely angry, aggrieved, or upset, it may be too difficult for them to deal therapeutically with their oppressive behaviors until they have cooled off a bit.

However, for some clients, extreme emotional states are prime opportunities to address their oppressive behaviors in a more immediate way.

- Consider the personal and social dynamics that are being re-enacted by both you and the client (my stuff, their stuff, our stuff).
- Allow the client's social history, presenting problems, and treatment goals to guide how best to navigate the encounter.

3. Decide How Best to Proceed

- Consider the nature and strength of the therapeutic relationship in your decision-making process.
- Weigh both addressing or not addressing the encounter—both options have consequences, such as:
  - Deciding to not address the encounter may communicate agreeing or colluding with the client or supporting the oppressive ideologies.
  - Addressing the encounter may be perceived as invalidating or judgmental, which may engender feelings of guilt, shame, confusion, embarrassment, and the like.
  - Addressing the encounter may also facilitate the client's social consciousness and motivation to be curious about their own socialization and how it influences relationships.
- Invite curiosity about personal and social dynamics that are being re-enacted in therapy. Again, consider the notion of "my stuff, their stuff, our stuff."
- Consider the timing—it may be that a more opportune time may be available in the future, especially depending on the nature of the therapeutic relationship, the content occurring in the moment, and the like.

4. Take Care of Your Wellness

- Pay attention to how the encounter makes you feel and impacts your sense of well-being and functioning.
- Allow yourself to take a wellness break to do things that are fulfilling and reduce your stress.
- Connect with or create a social support system that can help you process your emotions, reactions, validate your experiences, and affirm your humanity.
- Process the encounter in your own therapy or consider seeking therapy, which is a form of self-care for therapists.
- See Chapter 17 on creating and using strategies for self-care.

5. Consider Consultation
   - Connect with a trusted colleague who can help you:
     - Think through the encounter, identify things you may not be considering about the encounter, or provide ways to navigate the situation.
     - Process the emotions and reactions you experienced about the decision you made—if you had the opportunity for a redo what would you do differently?

Therapists Can Also Perpetrate Oppression

Therapists are not exempt from being unintentionally oppressive in the therapeutic context. We can do this in various ways including: (a) using offensive language in therapy; (b) invalidating or minimizing clients' experiences and narratives of oppression; (c) silencing or ignoring the clients' attempts to share the experiences of oppression and its impact in their lives; and (d) taking too much space in therapy and centering ourselves when the client discusses experiences of oppression and dehumanization (Lee, 2005; see also Ali et al., 2005). Consider the following testimony from a therapist who states

> I realize that when I hear about clients' painful experiences with racism, I quickly want to ease their pain and make it all right again. I also wish to alleviate my own anxiety and distress about racism and to preserve my efficacy as a good therapist and person. This is almost impossible. There are no easy answers to the racial problems experienced by our clients. Ironically, what most clients need is a container of safety and space to tell their truth and have it validated as just that. The "answer" may not be what is most important (Lee, 2005, p. 111).

ENGAGING IN SOCIAL JUSTICE ACTIONS

Moving beyond recognizing and naming human rights in our professional ethics requires a commitment to actions guided by a social justice ethos. In 1967, Dr. Martin Luther King, Jr. delivered a Distinguished Address to the Society for the Psychological Study of Social Issues at the American Psychological Association Convention. He discussed the failure of social scientists to contribute significantly to the Civil Rights Movement. He urged social scientists and practitioners to speak up about social injustices and not habituate to inhumanity. Dr. King states

> I am sure that we will recognize that there are some things in our society, some things in our world, to which we should never be adjusted. There are

> some things concerning which we must always be maladjusted if we are to be people of good will. We must never adjust ourselves to racial discrimination and racial segregation. We must never adjust ourselves to religious bigotry. We must never adjust ourselves to economic conditions that take necessities from the many to give luxuries to the few. We must never adjust ourselves to the madness of militarism, and the self-defeating effects of physical violence (1968, p. 185).

Psychologists of Color have extensively written about the importance of centering social justice in our work. At the 1968 APA convention, Dr. Joseph L. White, considered the father of Black Psychology, called on the field of psychology to acknowledge the way it had harmed Black people and other People of Color and commit to do better (Cokley et al., 2019: see also Cokley & Garba, 2018). Dr. White asked the board and APA to

> see African-Americans on their own terms and through a lens of resilience. While the board members initially balked—some even accused Dr. White of racism—his ideas gained a foothold in the field, setting the stage for the multicultural practice and research of today (DeAngelis, 2016, para. 2).

Dr. White envisioned and described a mental health profession where Black Americans would be viewed from a strengths-based approach—one where the lived experiences of Black, Indigenous, People of Color, and other historically minoritized groups would be a central component of psychotherapy. He described four principles of Black Psychology that can assist us all in engaging and committing to social justice in our work with all people including:

- Creating and maintaining a psychology that represents the voices of the people whose lives it seeks to improve. In other words, a psychology that embraces people who are diverse in terms of race, ethnicity, gender, ability, sexual orientation, religion and the like—and that are represented in theory, research, practice, and policy.
- Producing psychological knowledge that is accessible to laypersons. He discussed the importance and power of using clear language that is free of professional jargon, which in turn can increase understanding and usage of the knowledge produced by scholars and therapists.
- Make psychological knowledge available to the public (e.g., publish open-access content in magazines, blogs, social media, professional websites, instead of solely in professional journals).
- Using a strengths-based lens rather than a deficit- based perspective to make sense of clients and communities.

Guthrie's classic 1976 book, *Even the Rat Was White: A Historical View of Psychology* (2004), carefully documents how psychology was slow to recognize